83-163

IN THE

Supreme Court of the United States

October Term, 1983

JOHN M. SYRIA, DIRECTOR, DIVISION OF SOCIAL SERVICES, NORTH CAROLINA DEPARTMENT OF HUMAN RESOURCES, ET AL., PETITIONERS,

v.

CLARA ALEXANDER, ET AL.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

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ATTORNEYS FOR PETITIONERS

QUESTIONS PRESENTED

I. WHETHER THE DISTRICT COURT IS INVESTED WITH SUCH BROAD INHERENT EQUITABLE POWERS THAT IT HAD THE AUTHORITY TO IMPOSE REMEDIAL FINES ON THE PETITIONERS ABSENT A FINDING OF CONTEMPT OR BAD FAITH ON THEIR PART.

II. WHETHER THE SOCIAL SECURITY ACT AND ITS IMPLEMENTING REGULATIONS REQUIRE THAT THE PETITIONERS AND THE LOCAL DEPARTMENTS OF SOCIAL SERVICES BE IN ONE HUNDRED PER CENT (100%) COMPLIANCE WITH APPLICABLE FEDERAL TIME STANDARDS FOR PROCESSING AID TO FAMILIES WITH DEPENDENT CHILDREN AND MEDICAID APPLICATIONS.

PARTIES TO THE PROCEEDING

John M. Syria is the present Director of the Division of Social Services, North Carolina Department of Human Resources and, accordingly, is the substitute party petitioner for Renee Hill. The only other party petitioner to the proceeding is Sarah T. Morrow, current Secretary of the North Carolina Department of Human Resources, who is the substitute party petitioner for David T. Flaherty. Party respondents other than Clara Alexander are Carmen Nelson, Etter Hilton, Sarah Williams, Karen Brown, Bertha Suber and Henry J. Conner. These respondents sought to represent a class of applicants for and recipients of Aid To Families With Dependent Children and Medicaid who live in North Carolina. This class was in fact certified as a subclass by the District Court on May 7, 1975.

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The Attorney General of North Carolina, on behalf of the Director, Division of Social Services, North Carolina Department of Human Resources, and the Secretary of the North Carolina Department of Human, petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fourth Circuit in this case.

OPINIONS BELOW

The opinion of the Court of Appeals (App. A, *infra*, A1-A-9) is reported at 707 F. 2d. 780 (4th Cir. 1983). The opinion of the District Court (App. B, *infra*, A-10–A-26) is reported at 549 F. Supp. 1355 (W.D. N.C. 1982).

JURISDICTION

The judgment of the Court of Appeals was entered on May 5, 1983 (App. C, *infra*, A-27). The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

STATUTORY PROVISIONS INVOLVED

Relevant provisions of the Social Security Act, Title 42 of the United States Code, and pertinent regulations

promulgated thereunder, Titles 42 and 45 of the Code of Federal Regulations, involved in this case are reproduced at App. D, *infra*, A-29—A-62. Relevant provisions of the North Carolina General Statutes, Chapter 108A, involved in this case are also reproduced at App. D, *infra*, A-66–A-68.

CONSTITUTIONAL PROVISIONS INVOLVED

This case involves the Eleventh Amendment to the United States Constitution.

Amendment XI

The judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State, or by Citizens or Subjects of any Foreign State.

STATEMENT

A. Preface.

In this case the District Court has imposed on the Petitioners fines (called "remedial fines") which are indistinguishable from the fines which it would have imposed as a remedy for contempt. *However, the Court has imposed these fines without any finding of contempt or bad faith on the part of the Petitioners.* In effect, the Court's actions make all the precedent defining and restraining the contempt power of the judiciary superfluous and violate the Eleventh Amendment to the United States Constitution as well. Therefore, this case, which began as an injunctive and declaratory judgement action pursuant to 42 U.S.C. §1983 and 28 U.S.C. §§2201 and 2202 (jurisdiction being invoked under 28 U.S.C. §§1343(3) and (4) as well as 28 U.S.C. §1331) to construe and enforce the Social Security Act, has, in the main, come to concern the common law and constitutional powers of a United States District Court.

Moreover, this case has added to the serious conflict among the circuits over the proper standard of compliance

with the Social Security Act, a standard which is exceedingly important to those States whose human services programs are funded, in large measure, only if the applicable provisions of the Act are followed.

B. History of the Case.

This case, filed in 1974, is a class action against North Carolina officials (the Petitioners herein) for declaratory and injunctive relief on behalf of applicants in North Carolina for Aid to Families with Dependent Children (AFDC) and Medical Assistance (Medicaid). Social Security Act, Titles IV-A and XIX; 42 U.S.C. §§601, *et seq.* and §§1396, *et seq.* The class was certified as a subclass on May 7, 1975. Partial summary judgment was granted in favor of the Respondents on August 13, 1975. Since that time there have been other proceedings for additional relief resulting in refinements and changes in the Court's Orders.

The programs of public assistance at issue in this case, AFDC and Medicaid, are joint federal, State and county programs which have been authorized and created in North Carolina under N.C.G.S. §108A-25(a)(1) and §108A-25(b), respectively. Within North Carolina the State's Department of Human Resources is charged with supervising the programs. Under State law and in accordance with a federally approved State plan, the several counties are responsible for administering the programs within their jurisdiction in accordance with federal and State law and regulations. N.C.G.S. §§108A-25 and 108A-27. Among the counties' duties is the duty to take and decide public assistance applications in accordance with federal regulations. In North Carolina over nine thousand (9,000) such AFDC and Medicaid applications must be processed each month.

The substance of this case concerns North Carolina's obligation to process AFDC and Medicaid applications in a timely manner. Federal regulations require that applications be acted upon within forty-five (45) days of the date of

application, 42 C.F.R. §435.911(a) (2) and 45 C.F.R. §206.10(c) (3) (i), unless it is necessary, as part of a Medicaid eligibility decision, to decide whether an applicant is disabled. In that case the application must be decided within sixty (60) days of the date of application. 42 C.F.R. §435.911(a) (1) and 45 C.F.R. §206.10(c) (3) (ii). However, these time limits are subject to a broad exception which states that they do not apply in "unusual circumstances" such as, for example, an applicant's own failure to take action, and the like failure of some third party, or some administrative or other emergency. 42 C.F.R. §435.911(c) and 45 C.F.R. §206.10(c) (3) (ii).

In rendering partial summary judgement for the Respondents, the District Court found that North Carolina had not abided by the pertinent time limits for acting upon AFDC and Medicaid applications. In a series of subsequent order fashioning a remedy for the Respondents, the District Court went substantially beyond the text of the federal regulations cited above. In giving effect to the exception which states that the Petitioners may take more than forty-five (45) or sixty (60) days in unusual circumstances, 42 C.F.R. §435.911(c) and 45 C.F.R. §206.10(c) (3) (ii), the District Court created a complicated and cumbersome system of procedural checks and benchmarks for judging whether there was good cause for delaying the decision on a person's application beyond the forty-fifth (45th) or sixtieth (60th) day. Thus, the District Court ordered the Petitioners to ask the applicant for all necessary information known to be needed within twenty (20) days of the application. Additionally, the Court required, in cases where disability is an issue, that all the information necessary for a medical decision to be made be sent from the county to the State's Disability Determination Section within twenty-five (25) days of the time of application. If it becomes apparent that additional information will be needed, that information must then be requested by the Disability Determination Section within

five (5) days. Decisions must be made by the county departments within five (5) working days of the receipt of the needed information, unless there is more time than that available under the standard forty-five (45) and sixty (60) day rules. All such dates must be documented in the applicant's case file, and *the failure to document these dates* violates the Court's orders even though the acts were in actuality performed on time.

None of these procedural checks and benchmarks are contained in the federal regulations. All are created by the Court's own orders, and they as well as the attendant recordkeeping add to the already considerable—sometimes intolerable—stress placed on social services agencies. For example, no provision in the Court's orders is made for acts of God, broken equipment, or human error or frailties. The act of date-stamping an envelope, instead of the letter within, and then losing the envelope can rise to the level of a violation of the Court's orders. Indeed, such violations are inevitable in a system which processes over 9,000 AFDC and Medicaid applications every month. Nonetheless, it is violations of these orders on timely decisions which have been the primary focus of this litigation.[1]

C. The Present Proceedings.

On May 28, 1982, the Respondents filed a pleading

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[1]In addition to the matter of acting on applications in a timely fashion, this case originally involved several other issues. With respect to these issues, there have been many improvements since the initial substantive Court order granted in favor of the respondents in August of 1975. For example, the Amended Complaint sought several objectives which were indeed attained and with which the Petitioners have complied fully. The Petitioners have acknowledged their responsibility to insure that the programs are administered uniformly in all one hundred (100) counties of North Carolina. They have also undertaken to see that all AFDC and Medicaid applications have been accepted without delay, and they have seen to it that AFDC and Medicaid applicants obtain the full amount of retroactive benefits to which they are entitled. As to these matters, the Petitioners have complied fully with the Court's orders.

entitled "Motion for Further Relief." In this motion they sought to have the Petitioners held in contempt, penalized and ordered to pay damages for the alleged failure to comply with the District Court's earlier orders. The Respondents also sought modification of the earlier orders and an injunction forbidding certain practices which were alleged to be in violation of federal law or previous orders.

The Petitioners filed a Response denying the allegation and both sides filed Affidavits and Exhibits. The Motion was heard on August 2, 1982, and both sides presented testimony to supplement their Affidavits.

On November 4, 1982, the District Court issued its order. 549 F. Supp. 1355 (W.D.N.C. 1982); (App. A-10–A-26). While the District Court did not find the Petitioners to have been in contempt of its earlier orders, it did find that they had "seriously failed to comply with their obligations under federal Law and [its] orders." 549 F. Supp. at 1358; (App. B, A-18). Therefore, the Petitioners were ordered to pay a "remedial fine" to those AFDC and Medicaid recipients whose applications were overdue without good cause in violation of the Court's orders.[2]

The Petitioners moved to amend the order, and this Motion was allowed in part and denied in part on December 20, 1982.

On January 10, 1983, the Petitioners gave Notice of Appeal. Their Motions for a stay were denied, but the case was set for peremptory hearing. On May 5, 1983, the Court of Appeals for the Fourth Circuit affirmed the District Court in all respects.

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[2]The "remedial fines" and related costs have already exceeded one million dollars.

REASONS FOR GRANTING THE PETITION

A. THE DISTRICT COURT IS NOT INVESTED WITH SUCH BROAD INHERENT EQUITABLE POWERS THAT IT HAD THE AUTHORITY TO IMPOSE REMEDIAL FINES ON THE PETITIONERS ABSENT A FINDING OF CONTEMPT OR BAD FAITH ON THEIR PART.

The remedial fines imposed by the District Court are identical to fines which are lawfully and frequently imposed in cases of contempt of court. Notably, the present proceedings commenced with a motion asking that the Petitioners be found in contempt. However, citing only *Hutto v. Finney*, 437 U.S. 678 (1978), *the District Court imposed fines on the Petitioners*, for non-compliance with previous Court orders and to insure future compliance, *without actually finding contempt or bad faith*. 549 F. Supp. at 1359 and 1361; (App. B., *supra*, A-20–A-24). The Court of Appeals for the Fourth Circuit, on the basis of the District Court's "broad" "inherent equitable powers to achieve fair remedial results," upheld the imposition of these fines (App. A, A-4 and A-5).

The decisions below relative to the imposition of fines have no basis in the Social Security Act, the law of contempt or pertinent case law. Furthermore, they violate the Eleventh Amendment to the United States Constitution. Additionally, by upholding the imposition of remedial fines on the Petitioners, absent a finding of contempt or bad faith on their part, the Court of Appeals has inflated the equitable powers reposed in a federal District Court to an almost unfettered point and has decided an important issue in a way in conflict with prior applicable holdings of this Court.

First, it is significant that neither the District Court nor the Court of Appeals relied on the Social Security Act as authority for their decisions regarding the "remedial fines." In fact, the Act grant no such authority.

Second, in *Hutto v. Finney*, *supra*, the case relied upon by

the District Court, the Supreme Court's decision affirming the award of attorney's fees turned on an explict finding of bad faith which was equated with civil contempt.

> "Civil contempt may also be punished by a remedial fine, which compensates the party who won the injunction for the effects of his opponent's non-compliance." 437 U.S. at 691.

Nothing in *Hutto* authorizes fines without comparable supporting findings:

> "We hold that the District Court's award is adequately supported *by its finding of bad faith*..." 437 U.S. at 689 (emphasis supplied).

Third, the District Court's emphasis on the remedial nature of the fines does not provide an independent basis for imposing them apart from the law of contempt. In fact, punishment for civil contempt is remedial punishment. *Gompers v. Bucks Stove & Range Co.*, 221 U.S. 418 (1911); *McComb v. Jacksonville Paper Co.*, 336 U.S. 187 (1948). It is clear then that the "remedial fines" imposed by the District Court in this case are in the nature of punishment for civil contempt. When the District Court imposed remedial penalties without any finding that the Petitioners were in contempt or had even acted in bad faith, it either violated the traditional law of conte..apt or rendered it moot and superfluous.

Fourth, the District Court violated the Eleventh Amendment's proscription against federal courts imposing fiscal burdens on the State which are more than ancillary to the State's obligations of future compliance with the orders of the Court. By the very language of the District Court order itself, it is patent that the fines are more than ancillary to future compliance;[3] and, therefore, in the absence of an

[3]"That in view of defendant's protracted non-compliance with previous court orders, but principally to insure future compliance, defendants are ordered to pay each applicant who is determined to be eligible for AFDC or Medicaid a remedial fine of fifty dollars ($50.00) for each week or fraction thereof that his or her appliction was delayed beyond the relevant time limit without 'good cause'." 549 F. Supp. at 1361; App. B, A-24.

express finding of contempt or bad faith on the part of the Petitioners, these fines do violence to the Eleventh Amendment to the United States Constitution. *Edelman v. Jordan*, 415 U.S. 651 (1974); *Quern v. Jordan*, 440 U.S. 332 (1979); *Hutto v. Finney, supra; Milliken v. Bradley*, 433 U.S. 267 (1977).

Finally, that a federal District Court can proceed to impose a substantial burden on a State's public fisc without any authority other than "broad" "inherent equitable powers to achieve fair remedial results" invests the federal judiciary with dangerously subjective powers. Allowing a District Court to make dispositions solely under such a nebulous, abstruse principle represents a dramatic departure from its traditional mandate to interpret and apply the laws and provisions of the Constitution.

Even the lead case relied on by the Court of Appeals as sustaining the District Court's authority to award equitable relief, *Smith v. Miller*, 665 F. 2d 172 (7th Cir. 1981), recognized that there are limitations to the excercise of a court's powers of equity when it cited and distinguished the case of *Wright v. Califano*, 587 F. 2d 345 (7th Cir. 1978). Likewise, this Court has just recently rendered an opinion striking down a sweeping "remedial" order by a federal court for failure to satisfy the preconditions for equitable relief. *City of Los Angeles v. Lyons*, ____ U.S. ____, 103 S. Ct. 1660 (1983).

In the Fourth Circuit, however, litigants are now faced with the unsettling possibility that a District Court's "broad" "inherent equitable powers to achieve fair remedial results" may produce unforeseen and unconventional relief. Those charged with the responsibility of administering governmental programs are not likely to be comforted by the knowldege that, in the name of equity, fiscal sanctions may be assessed without even an express finding of bad faith on their part.

This Court should take the opportunity to review this case which serves as a perfect example of what the unbridled

power of a federal court can lead to.

B. THERE IS A SERIOUS CONFLICT AMONG THE COURTS OF APPEALS AS TO WHETHER THE SOCIAL SECURITY ACT AND ITS IMPLEMENTING REGULATIONS REQUIRE FULL COMPLIANCE WITH APPLICABLE TIME STANDARDS FOR PROCESSING AID TO FAMILIES WITH DEPENDENT CHILDREN AND MEDICAID APPLICATIONS.

There is a serious split of authority among the circuits on the question of whether a federal Distrcit Court has the power to require full compliance with the terms of a statute establishing a scheme of cooperative federalism,[4] or may remedy only violations of such a proportion that it can be said that the State has not substantially complied with the requirements of the statute. The instant case[5] and seemingly *Smith v. Miller*,[6] *supra*, require one hundred per cent

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[4]"The law requires that *all* applications—not merely a substantial percentage of them—be processed within the relevant time limits." *Alexander v. Hill*, *supra*, 549 F. Supp. at 1359; App. B, A-19.

[5]"The defendants' objection to the 100% applicability of the relief ordered, based on a claim that it is too Draconian, need not long detain us. The district court had wide discretion in fashioning a remedy which would achieve compliance with the law. The law itself compels 100% compliance. See, *e.g.*, 42 U.S.C. §602 ("aid to families with dependent children shall... be furnished with reasonable promptness to all eligible individuals"). The district court did not abuse its discretion when it required full compliance with the law and imposed a sanction for any failure to comply. We are all expected to abide fully by the law, and expose ourselves to sanctions whenever we fail to do so. App. A, A-7.

[6]A State "must fully comply with federal statutes and regulations in its administration of the [Medicaid] program." 665 F. 2d at 175. However, the Court went on to comment:

"The problem is further complicated because it is difficult, if not impossible, for the district court to fashion a remedy which both compensates recipients for losses suffered from administration delays and guarantees that the agency will *substantially comply* with the statutory requirements..." 665 F. 2d at 177 (emphasis supplied).

(100%) compliance with the applicable provisions of the Social Security Act, while *Shands v. Tull*, 602 F. 2d 1156 (3rd Cir. 1979)[7] and *Fortin v. Commissioner of the Massachusetts Department of Public Welfare*, 692 F. 2d 790 (1st Cir. 1982)[8] recognize a less stringent standard.

Common sense alone would suggest that the more stringent standard is impossible and, therefore, must not be the law. Put another way, the law and regulations cited surely comtemplate less than perfect compliance; such a standard would simply be unreasonable and unrealistic.

The Social Security Act certainly contains authority for the proposition that substantial compliance with its terms is all that is required of a State. For example, the Secretary of Health and Human Services is authorized to discontinue furnishing federal funds to a State if he finds that in the administration of the AFDC and Medicaid programs, *"there is a failure to comply substantially"* with the requirements of the particular program. 42 U.S.C. §604(a) (2) and §139c(2). For another example see 42 U.S.C. 1396b(g) (4) (B) (i) concerning inspection of hospitals, skilled nursing facilities and intermediate care facilities.

Plainly, *Shands v. Tull, supra,* and *Fortin v. Commissioner of the Massachusetts Department of Public Welfare, supra,* recognize the proper standard, that of substantial compliance. Review is required, however, to resolve the pressing conflict between those cases, on the one hand, and the present case and *Smith v. Miller, supra,* on the other.

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[7] "...the scheme of the Social Security Act reveals a congressional intent to require only substantial compliance from the States." 602 F. 2d at 1160.

[8] "Finally, no particular percentage of compliance can be a safe-harbor figure, transferable from one context to another. Like 'reasonableness' [citation omitted] 'substantiality' must depend on the circumstances of each case, including the nature of the interest at stake and the degree to which non-compliance affects that interest. . . . It is for this reason that the 96% compliance rate in *Shands v. Tull, supra,* cannot be a touchstone of substantiality." 692 F. 2d at 795.

CONCLUSION

The Petitioner for a Writ of Certiorari should be granted.

Respectfully submitted,

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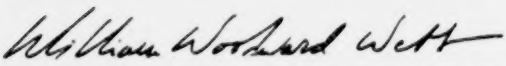
Assistant Attorney General



WILLIAM WOODWARD WEBB

APPENDICES

APPENDIX A

United States Court of Appeals

PUBLISHED

FOR THE FOURTH CIRCUIT

No. 83-1088

Clara Alexander, Carmen Nelson, Etter Hilton and Sarah Williams individually and on behalf of all others similarly situated; Henry J. Conner,

Appellees,

v.

Renee Hill, Director, Division Social Services, North Carolina State Department of Human Resources; James F. Richardson, Mecklenburg County Board of Social Services; Edwin H. Chaplin, Director, Mecklenburg County Department of Social Services,

Appellants.

Appeal from the United States District Court for the Western District of North Carolina, at Charlotte. James B. McMillan, District Judge.

Argued March 1, 1983 Decided May 5, 1983

Before PHILLIPS, MURNAGHAN, and ERVIN, Circuit Judges.

William Woodward Webb; Steven Mansfield Shaber, Assistant Attorney General (Rufus L. Edminsten, Attorney General of North Carolina on brief) for Appellants; Theodore O. Fillette, III, Legal Services of Southern Piedmont, Inc. (Pam Silberman, Legal Services of Southern Piedmont, Inc. on brief) for Appellees.

MURNAGHAN, Circuit Judge:

In August 1974 plaintiffs sued North Carolina State and County administrators to compel them to correct a situation in which benefits under the Medicaid and the Aid for Dependent Children programs were delayed beyond elapsed time limits established by applicable federal regulations.[1]

It is not necessary that we here spell out the tangled web which has confronted the plaintiffs. It suffices to observe that in 1983, over eight years since their case was brought, North Carolina's Secretary of Human Resources and Director of Social Services have not yet brought the AFDC and Medicaid programs into full compliance with the time limits called for the regulations. On record evidence supporting them,[2] the district judge made findings as follows:

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[1]Applications are to be processed within 45 days of filing or, where disability is claimed, within 60 days. 42 C.F.R. § 435.911; 45 C.F.R. § 206.10(a)(3).

The regulations further require a state to supervise administration of the AFDC and Medicaid programs and to insure that the counties process applications in a timely fashion. 42 C.F.R. § 435.904; C.F.R. §§ 205.120, 206.10(a)(12).

[2]The defendants have not challenged any of the district court's findings; nor have they moved for any amendment of the substantive findings.

* * *

3. Mecklenburg County has shown a consistent pattern of non-compliance...

4. Both Wake and Stokes Counties submitted inaccurate monthly reports...

5. In the counties investigated by plaintiffs, defendants improperly classified as overdue with "good cause" cases [improperly so classified]...

6. ...

The court finds that plaintiffs' investigation raises questions about the accuracy of defendants' monthly reports state-wide...

8. In summary of the above findings, the court finds that while defendants have made some progress in the eight years since this action commenced, they have still seriously failed to comply with their obligations under federal law and this court's orders.

The district court concluded as a matter of law that there has been widespread failure by the defendants to comply with previous orders entered in the proceeding. The court specifically mentioned submission by the defendants of inaccurate monthly reports and the defendants' improper classification of applications as overdue with good cause. The district judge further faulted defendants' practice of delaying decision on Medicaid applications beyond 60 days in order to adopt Social Security disability determination in violation of federal regulations and previous orders of the court.

In structuring a remedy the court provided:

That in view of defendants' protracted non-compliance with previous court orders, but principally to insure future compliance, defendants are ordered to pay each applicant who is determined to be eligible for AFDC or Medicaid a remedial fine of fifty dollars ($50.00) for each week or fraction thereof that his or her application was delayed beyone the relevant time limit without "good cause." Defendants will be given ninety (90) days from the date of this order to bring the county departments into compiance with federal law and the terms of this order. At the end of ninety (90) days, defendants are ordered to send each applicant who is sent an initial AFDC check or favorable Medicaid notice of decision a separate check in the amount required by the terms of this paragraph. A decision by defendants that an applicant is not entitled to payment provide for by this paragraph shall be subject to the statutory appeals procedure. **See** N.C.G.S. §108A-79.

That any money paid to an applicant as a result of this order shall not be recoverable by defendants. Nor shall the money paid to a successful applicant be treated as income or reserve for the purpose of determining public assistance eligibility of benefit levels.

I. The Absence of a Finding of Contempt or Bad Faith as Precluding the Imposition of a Remedial Fine

On appeal, the defendants first have contended that the district court lacked authority to impose remedial fines or penalties absent a finding of contempt or bad faith. However, words are possessed of no magical properties, incantations should not decide cases, and the lack of a finding of contempt or of bad faith should not preclude exercise of inherent equitable powers to achieve fair remedial results. **Smith v. Miller,** 665 F. 2d 172, 175 (7th Cir.

1981) ("As the Department points to no explicit provisions within the Act and no ground in the Constitution which restricts the district court's authority to award equitable relief, the district court had authority to exercise its full powers of equity to effectuate the purpose of the Act."); **Class v. Norton,** 505 F 2d 123, 125 (2d Cir. 1974) ("... the court eschewed the requested contempt sanctions in favor of a detailed implementation plan designed to eliminate possible source of continued non-compliance..."); **cf. Rodriguez v. Swank,** 496 F. 1110 (7th Cir. 1974) (action by the district court substantially identical to Judge McMillian's in the instant case was denominated on appeal a civil contempt order, although the opinion contains no indication that a finding of contempt had been made in the district court). The court is invested with broad equitable powers and simply should be compelled to operate in a punishment or nothing atmosphere. Alleviation rather than sanction was properly the goal on which the district court concentrated its attention.

II. The Eleventh Amendment to the Federal Constitution as a Bar to the Awards of Remedial Fines

The defendants assert that the district court's contingent remedy is barred by the Elevent Amendment provision:

> The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens...

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[1]Indeed, in **Class v. Norton,** the relief awarded was far more extensive than here, for the State Commissioner of Welfare was in **Class v. Norton** ordered to mail assistance checks to every applicant upon the expiration of the applicable period (then 3 days) without completion of processing and, in that connection, to find presumptively eligible all applicants whose applications had not been processed within the requisite period. The order in the instant case restricts relief to those in fact determined to be eligible for benefits. In **Smith v. Miller,** the Seventh Circuit approved a provision in the order that all untimely processed applications should be automatically approved.

The district judge here further excepted applicants whose applications took more than 45 days or 60 days to process for "good cause."

We need not elaborate on the history of the interpretation accorded to that Amendment, and its long-standing record of meaning something different—or at least more extensive—than what it seems to state. The crucial consideration is simply that the remedial awards are entirely prospective. They are contingent upon what happens in the future. The defendants were accorded 90 days from the date of the district court's order in which to bring their practices into compliance with the governing regulations. Had they succeeded in doing so, no remedial fines would have ever been payable. Any remedial fines that might now be paid are strictly *in futuro* dating from February 4, 1983, 90 days after the district court's order.

Had the award been retrospective in charcter then we would have been presented with a very different case under the Eleventh Amendment. **Cf. Edelman v. Jordan**, 415 U.S. 651, 665 (1974). However, the Supreme Court in **Edelman** makes clear that only **retroactive** monetary relief is prohibited by the Eleventh Amendment and that prospective relief does not violate the Amendment, even though it has a significant "ancillary effect on the state treasury." **Id** at 667-68.

The distinction between prospective and retrospective relief is further refined in **Milliken v. Bradley**, 433 U.S. 267, 289-90 (1977) (approving a decree requiring the State "to share the future cost" of the relief imposed, the Supreme Court approved action by the "federal courts to enjoin state officials to conform their conduct to requirements of federal law, notwithstanding a direct and substantial impact on the state treasury... That the programs are also 'compensatory' in nature does not change the fact that they are part of a plan tha operates **prospectively** to bring about the

delayed benefits of a unitary school system. We therefore hold that such prospective relief is not barred by the Eleventh Amendment") (emphasis in original).

III. **The Requirements of 100% Compliance with the Federal Regulations**

The defendants' objection to the 100% applicability of the relief ordered, based on a claim that it is too Draconian, need not long detain us. The district court had wide descretion in fashioning a remedy which would achieve compiance with the law. the law itself compels 100% compliance. **See, e.g.,** 42 U.S.C. §602 ("aid to families with dependent children shall. . . be furnished with reasonable promptness to all eligible individuals"). The district court did not abuse its discretion when it required full compliance with the law and imposed a sanction for any failure to comply. We all are expected to abide fully by the law, and expose ourselves to sanctions whenever we fail to do so.

IV. **Possible Penalties or Other Undesirable Results from the Court's Ban on Taking into Account the Remedial Fines in Determining Eligibility or Benefit Levels under Public Assistance Programs.**

A. Appellants seek to utilize a letter dated February 1, 1983[4] from the United States Secretary of Health and Human Services, Richard S. Schweiker, to counsel for the Appellants to suggest collateral detrimental effects to them which will flow from the portion of the order forbidding the calculation of public assistance eligibility by treating as an asset any remedial fine paid to an AFDC or Medicaid beneficiary who has been subjected to an unwarranted delay in the processing of his or her application for benefits. In the

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[4]The letter was written during the pendency of the appeal, after the record was complete.

first place it remains for future determination whether any remedial fines will in fact be paid. An objective of the district court order is to obtain compliance with applicable federal regulations, and we do not lightly assume that the order will not have the desired effect. Second, the federal regulations to which Mr. Schweiker's letter was directed, 45 C.F.R. §233.20; 42 C.F.R. §435, Subparts H and I, were written with attention focused on other matters than remedial orders of the type here involved, which have been imposed by the judiciary. Courts may tailor their orders to obtain the desired effect without being frustrated by federal regulations promulgated with other purposes in mind. It remains for future determination in another law suit whether the remedial, court-ordered fines will be deemed to trigger those federal regulations.[5] Moreover, Judge McMillan is not precluded from considering modification of his order should the regulations in fact be subsequently interpreted to be in conflict with that portion of his order. Third, Mr. Schweiker himself points to the availability of waivers of any penalties under the applicable regulations where the state has made a "good faith effort." It is, therefore, entirely possible that North Carolina and its counies, by a display of good faith, even if they do not escape all remedial fines, may qualify for and reveive waivers under the federal regulations from which they otherwise fear the imposition of penalties.

Finally, the restrictions appearing in the order may well be essential to its efficacy. Obviously if the remedial fines

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[5]We do not accept as controlling an observation by a fellow administrative official, designed to assist a party to litigation, to the effect that "I understand that under current policy the payments required by the Court's Order in **Alexander v. Hill** would be considered income or resources for purposes of eligibility determination." The observation is just that. It cites not authority, merely purporting to rely on "consultation with the Office of the General Counsel and review by the relevant program officials."

imposed to insure future compliance are subject to the state's taking away with one hand what it has been forced to give with the other, the effectiveness of the remedy will have been diluted or, indeed, will have almost entirely evaporated.

B. Furthermore, Appellants protest the extension of the ban on use of remedial fines to compute public assistance eligibility to other programs than AFDC and Medicaid. Superficially, the argument has some appeal, since, as the case has evolved, it has restricted itself solely to consideration of AFDC and Medicaid benefits. However, the State administers and at least partially funds all other public assistance programs. Indeed, the same state defendants also administer the Food Stamps and Energy Assistance programs. By imposing the condition, the district court was protecting the order against dilution and consequent dimunition of its remedial effectiveness. the order does not, in any way, interfere with the administration of public assistance programs other than Medicaid and AFDC, serving only to prevent the State from converting a Medicaid or AFDC benefit into a dollar loss to recipients under other public assistance programs.

Accordingly, for the reasons heretofore given, the judgment of the district court is

AFFIRMED.

Clara ALEXANDER, et al., Plaintiffs,

v.

Renee HILL, et al., Defendants.

No. C-C-74-183-M.

United States District Court,
W.D. North Carolina,
Charlotte Division.

Nov. 4, 1982.

Motion was filed to hold state welfare officials in contempt of court order requiring them to develop and implement a plan for timely taking of and processing of application for aid to families with dependent children and medicaid and to award penalties, etc. The District Court, McMillan, Jr., held that: (1) the law requires that all applications, not merely a substantial percentage, be processed within the relevant time limits, and (2) in view of protracted noncompliance defendants were ordered to pay each applicant who was determined to be eligible for benefits a remedial fine of $50 for each week or fraction thereof that his or her application was delayed beyond the relevant time without good cause.

Prior orders modified and continued.

1. Social Scurity and Public Welfare

All applications for aid to families with dependent children and medicaid and not merely a substantial percentage thereof must be processed within the relevant time limits.

2. Social Security and Public Welfare

Welfare officials' practice of delaying decision on medicaid applications beyond the 60-day regulatory period in order to adopt the social security unit's disability determinations violated federal regulations and court order to develop and implement a plan for timely taking and processing of applications.

3. Social Security and Public Welfare

District court had power to impose a remedial money sanction on state welfare agencies to secure compliance with court order requiring the agency to develop and implement a plan for timely taking and processing of applications for aid to families with dependent children and medicaid.

4. Social Security and Public Welfare

State welfare officials were ordered to limit concept of "good cause" for delayed processing of applications for aid to families with dependent children and medicaid to cases in which information necessary to determine eligibility was not provided by the applicant or by any source within 60 days of date of application and cases where disability was an issue and within 45 days in all other cases.

5. Social Security and Public Welfare

In view of welfare officials' protracted noncompliance with prior court orders to develop and implement a plan for timely taking of an processing applications for aid to families with dependent children and medicaid it was ordered that each applicant who was determined eligible to paid a remedial fine of $50 for each week or fraction thereof that his or her application was delayed beyond the relevant

time limit without "good cause," which money was not recoverable or to be treated by successful applicant as income or reserve for purpose of determining public assistance eligibility or benefit levels.

Theodore O. Fillete, Jr. and Lark hayes, Legal Services of Southern Piedmont, Charlotte, N.C., for plaintiffs.

Reita P. Pendry and Pam Silberman, Charlotte, N.C., for intervening plaintiff.

Steven M. Shaber, Asst. Atty. Gen., N.C. Dept. of Justice, Raleigh, N.C., and William H. McNair and Marvin A. Bethune, Ruff, Bond, Cobb, Wade & McNair, Charlotte, N.C., for defendants.

ORDER

McMILLAN, District Judge.

This suit has been pending over eight years. In 1975, the court originally determined that defendants were not complying with the law. It is time to get on with compliance. Although in large part this order simply restates previous orders, the court now finds it necessary to take measures to bring defedants in line with their obligations under those orders and federal law.

On August 28, 1974, plaintiffs filed this suit alleging that defendants and their local agencies were not processing applications for Aid to Families with Dependnet Children ("AFDC") and Medicaid in a timely fashion. Federal regulations require that AFDC and Medicaid applications be processed within forty-five (45)days of filing, except for those applications for Medicaid based on disability, which must be processed in sixty (60) days. 42 C.F.R. §435.911; 45

C.F.R. § 206.10(a)(3). The state defendants are required by the regulations to supervise the administration of the AFDC and the Medicaid programs and to insure that the counties process applications in timely fashion. 42 C.F.R. § 435.904; 45 C.F.R. §§ 205.120 and 206.10(a)(12).

On August 8, 1975, the court ordered defendants to develop and implement a plan for the timely taking and processing of applications. Since then, plaintiffs have applied to this court on numerous occasions for further relief to insure timely processing. On November 14, 1977, the court ordered defendants to take further steps to insure that all AFDC and Medicaid applications are timely processed, unless they are overdue with "good cause" as specifically defined in the court's order. The court also directed defendants to submit to the court and to plaintiffs counsel monthly reports showing the number of applications pending *with* "good cause" and *without* "good cause" in each county of the state. The court warned defendants that if they failed to secure complaince with the order to timely process, it would consider assessing liquidated damages in favor of eligible applicants whose applicantions are delayed without good cause.

Following another motion by plaintiffs for further relief, the court, in an order of March 30, 1979, supplemented and clarified its previous orders, but again declined to impose sanctions on the defendants for their failure to bring the state's AFDC and Medicaid programs into compliance with federal law.

On October 23, 1981, plaintiffs moved the court to allow them access to the records of five county departments of social services so that they could investigate continued delays in the processing of AFDC and medicaid

applications and could verify the monthly reports filed by defendants pursuant to the court's orders. Plaintiffs expressed skepticism about the accuracy of these reports. They pointed out, for example, that as of June 30, 1981, over 85% of all pending AFDC applications in the state had been pending 40 days or longer, yet the state classified only 5.2% of these as pending without "good cause." The court ordered defendants to provide plaintiffs access to the records as requested.

After investigating the records of Mecklenburg, Wake and Stokes counties, plaintiffs filed yet another motion for further relief. Plaintiffs alleged that Mecklenburg County had consistently reported a substantial percentage of it cases pending *without* "good cause," yet no efforts had been made by the defendants to correct tis poor performance. In the other two counties, the reported percentage of cases pending without "good cause" was much smaller; however, plaintiffs, on the basis of their investigation, atacked these statistics as severely inaccurate. They claimed that in periods in which Wake and Stokes counties had reported *no* cases pending without "good cause," over 30% of those counties' cases pending 40 days or more were in fact pending *without* "good cause."

Plaintiffs moved the court to find defendants in contempt, to award plaintiffs penalties, damages and attorneys' fees, and to clarify and supplement the court's previous orders.

Defendants oppose plaintiffs' motion. They also ask the court to reduce from twelve (12) months to six (6) months the period during which AFDC and Medicaid applications must be held open.

The motions came on for hearing on August 2, 1982, with both sides represented by counsel. Based on the oral testimony at the hearing and all documents of record, the court makes the following findings of fact and conclusions of law.

A. FINDINGS OF FACT

1. Plaintiffs investigated a statistically significant random sample of cases pending 40 days or more as of Agusut 31, 1982, in Mecklenburg and Wake counties. Plaintiffs investigated all of the cases pending 40 days or more as of January 31, 1982, in Stokes County.

2. Plaintiffs' investigation of Mecklenburg County confirms the essential accuracy of Mecklenburg County's monthly reports for the month ending August 31, 1981. Defendants' monthly reports and the plaintiffs' investigation show that approximately 17% of the AFDC cases and 21% of the Medicaid non-disability cases pending 40 days or more were overdue (*i.e.*, pending beyond the federally imposed time standards) without "good cause."

3. Mecklenburg County has shown a consistent pattern of non-compliance with the court's April 3, 1979, injunction that defendants process AFDC and Medicaid applications within 45 days (or 60 days in cases based on disability). For example, defendants' monthly reports for the months ending October 31, 1981, through May 31, 1982, indicate that between 14.0% and 17.7% of the total AFDC cases and between 9.2% and 18.9% of the total medicaid cases were overdue without "good cause." See attachments to the Affidavit of Q. Uppercue, dated July 27, 1982. 4. Both Wake and Stokes counties submitted inaccurate monthly reports during the period investigated by plaintiffs. Both

counties had reported that *none* of their cases were overdue without good cause for the months in question. The parties *stipulated* at the hearing, however, that at least 27.6% of the cases pending 40 days or more in Wake County and at least 9% of the cases pending 40 days or more in Stokes County should have been classified as overdue without "good cause."

5. In the counties investigated by plaintiffs, defendants improperly classified as overdue *with* "good cause" cases in which the following occurred:

(a) The county failed to notify the applicant within 20 days of the date of application of the information known to be needed to approve the application;

(b) The county failed to process the application within five working days of the receipt of the last necessary information;

(c) The county failed to document the receipt of the last piece of necessary information;

(d) The county failed to process the application within applicable time limits even though all necessary information was in the file;

(e) The county failed to send information to the State Disability Section within 25 days of the date of application; and

(f) The Medicaid unit of the Disability Determination Section delayed the case beyond the 60-day day time limit by waiting to adopt the Social Security unit's disability determination.

6. Defendants monthly reports indicate that only approximately 2.1% of all cases throughout the state at large were overdue without "good cause" for the months ending

October 31, 1981, through May 31, 1982. *See* Affidavit of Q. Uppercue, dated July 23, 1982 at ¶4. Defendants submitted affidavits from the directors of social services of the 97 counties not investigated by plaintiffs which stated that they knew and understood the processing and reporting requirements of this court's previous orders, and that they were accurately reporting the number of cases that were overdue without "good cause."

The court finds that plaintiffs' investigation raises question about the accuracy of defendants' monthly reports state-wide. These doubts are compounded by the fact that some counties with a huge number of overdue cases classified only a handful as overdue without "good cause." For example, Cumberland County reported that it was responsible for the delay of only 7 of its 795 overdue AFDC applications and only 13 of its 1,073 overdue Medicaid applications.

Defendants have not investigated the accuracy of reports from any county other than the three investigated by palintiffs. The court's doubts are not laid to rest by the self-serving form affidavits of the county directors.

7. Some delays in Medicaid cases involving "spend down" may be going unreported by the counties. A Medicaid applicant who meets all eligibility requirements but has excess income may be preliminarily "certified" for Medicaid though required to "spend down" the excess income on medical expenses before being "authorized" for Medicaid coverage. This arrangement is similar to a deductible clause in a private insurance policy. The applicant must provide information to the county to show that the deductible requirement has been met.

The court finds that once an applicant has been preliminarily "certified" for Medicaid benefits, the case is no

longer included in the monthly reports. The monthly reports, then, do not reflect delays which occur after the "certified" applicant has provided all the necessary information and is awaiting "authorization" for Medicaid coverage.

8. In summary of the above findings, the court finds that while defendnats have made some progress in the eight years since this action commenced, they have still seriously failed to comply with their obligations under federal law and this court's orders.

9. One of the most significant reasons for the delays in processing AFDC and Medicaid applications is the lack of sufficient county staff. State defendants have long been aware of this problem but have failed to take action to remedy it.

10. Defendants have further delayed the processing of Medicaid applications by refusing to treat applications for retroactive and prospective Medicaid coverage separately. Such delays are not reflected in defendants' monthly statistics.

Defendants acknowledge the good sense of processing these two types of applications separately since the county may have the information necessary to process one but not the other. Defendants therefore have indicated their agreement henceforth to require their local agencies to process retroactive and prospective Medicaid applications separately.

B. CONCLUSIONS OF LAW

[1] 1. Federal law requires defendants and their local agencies to make prompt decisions on applications for AFDC and Medicaid. Except under circumstances beyond defendants' control, such applications must be processed

within forty-five (45) days (or within sixty (60) days in cases involving a disability determination). For AFDC cases, these time standards are computed from the date of application to the date the assistance check, or notice of denial of assistance, is mailed to the applicant. 45 C.F.R. § 206.10(c)(3)(i) and (ii). For Medicaid cases, these time standards are computed from the date of application to the date the notice of decision is mailed to the applicant. 42 C.F.R. § 435.911(a) and (b). The law requires that *all* applications — not merely a substantial percentage of them — be processed within the relevant time limits.

2. The defendants failure to insure that all counties timely process AFDC and Medicaid applications violates the court's previous orders and the federal regulations. Defendants have neglected their statutorily imposed and court-ordered duty to supervise the counties administration of public assistance programs and take corrective action when necessary. 42 C.F.R. § 435.904; 45 C.F.R. §§ 205.120, 206.10(a)(12).

3. The defendants' submission of inaccurate monthly reports on the counties' processing activity also violates the court's previous orders. Defendants have a duty under the court's orders and federal regulations to stay currently informed of the counties adherence to the processing standard and defendants have failed to do so. 42 C.F.R. § 435.904, 45 C.F.R. §§ 205.120, 206.10(a)(12).

4. Defendants' improper classification of applications as overdue *with* "good cause," as described in ¶5 of the findings of fact, violates ¶1-5 of this court's order of March 30, 1979.

[2] 5. Defendants' practice of delaying decision on Medicaid applications beyond sixty days in order to adopt

the Social Security unit's disability determination violates federal regulations and this court's previous orders. See 42 C.F.R. § 435.911, 45 C.F.R. § 206.10(a)(3)(ii).

6. "Authorization" is part of the Medicaid eligibility process and must be done within the appropriate time limit when the applicant has provided all necessary information. 42 C.F.R. § 435.732(d).

[3] 7. The court has the power to impose a remedial money sanction on a state agency in order to secure compliance by the agency with the court's orders. *Hutto v. Finney*, 437 U.S. 678, 691, 98 S. Ct. 2565, 2573, 57 L.Ed.2d 522 (1978).

Based on the foregoing findings of fact and conclusion of law,

IT IS HEREBY ORDERED:

1. That the previous orders in this case continue in effect as modified herein.

2. That in cases where disability is an issue the defendants shall designate each overdue application for AFDC or Medicaid as overdue either *with* "good cause" or *without* "good cause" as of the 60th day after the date of application; in all other cases they shall make such designation on the 45th day after the date of application.

[4] 3. (a) That the defendants shall limit the concept of "good cause" for delay to cases in which the information necessary to determine eligibility was not provided to the department by the applicant or by other sources within sixty (60) days of the date of application in cases where disability is an issue, and within forty-five (45) days in all other cases.

(b) That defendants shall not classify a case as overdue *with* "good cause," but shall classify it as overdue *without*

"good cause," unless it appears from the documents in the applicant's file at the county department of social services that

> (i) the applicant was notified in writing within twenty (20) days of the date of application of *each specific piece of information* needed for processing the application; and
>
> (ii) if the need for additional information subsequently arose, the applicant was notified in writing of the specific information needed within five (5) working days of the date on which the need for new and additional information become known to the county; and
>
> (iii) in applications where disability is an issue, all necessary information was sent by the county office to that Disability Determination Section within twenty-five (25) days of the date of application, unless circumstances beyond the control of the county agency, documented in the case file and the agency, make it impossible for the county to comply.

Defendants, however, may reclassify a case covered by the terms of this subparagraph 3(b) as overdue *with* "good cause" after delay caused by the applicant has exceeded the delay caused by the defendants. For example, if defendants do not notify an applicant of all the information needed to process his or her application until *thirty* days after the application is filed (i.e., ten days more than the twenty days allowed by this paragraph), the case shall be classified on the forty-fifth day as overdue *without* "good cause" even though the applicant has not supplied all necessary information. But if the information has still not been supplied as of the *fifty-fifth* day (i.e., after ten more days),

defendants may reclassify the application as overdue with "good cause."

4. That each month defendants shall classify all Medicaid applications which are "certified" but not yet "authorized" and are pending forty-five (45) days or (sixty (60) days when disability is an issue) as overdue with "good cause" or without "good cause." Defendants shall limit the concept of "good cause" for delay in processing these applications to cases in which the information necessary to "authorize" the application has not yet been provided to the department by the applicant.

5. That absent a document change in circumstances, the defendants shall designate each overdue AFDC and Medicaid application, including those covered by ¶4 of this order, as overdue *without* "good cause" on the fifth working day after the documents in the applicant's file show that the department received the information necessary to determine eligibility which had previously delayed the case.

6. That defendants shall continue sending monthly reports to plaintiffs' counsel showing all AFDC and Medicaid applications (including reinstatements), which are pending more than forty-five (45) days (or sixty (60) days when disability is an issue) in each county. The statistics will reflect the classification of overdue *with* "good cause" and *without* "good cause" as defined in this order.

7. That defendants shall designate each overdue application pending at the Disability Determination Section as either overdue *with* "good cause" or overdue *without* "good cause" as of the sixtieth day after the date of application. Defendants shall limit the concept of "good cause" for delay in processing applications where disability is an issue to cases where the documents in the applicant's

file at the Disability Determination Section show the following:

(a) All additional medical evidence known to be necessary to determine eligibility was requested within the first five (5) days of receipt of the application by the Disability Determination Section and this information has not yet been received; and

(b) The disability decision has been mailed to the county department of social services within seven (7) working days of the receipt by the Disability Determination Section of medical evidence necessary to determine eligibility.

The Medicaid unit's reliance upon the Social Security unit's disability determinations shall in no way excuse defendants from this definition of "good cause."

8. That the defendants shall submit to plaintiffs' counsel a monthly report of the total number of cases received by the Disability Determination Section each month, as well as the number of cases overdue with "good cause" and overdue without "good cause."

9. That defendants, their successors, and all employees and agents of the Department of Human Resources (DHR) hereby continue to be enjoined to process all AFDC and Medicaid applications within forty-five (45) days (or sixty (60) days when disability is an issue), unless they are classified as overdue with "good cause" according to the terms of this order.

10. That defendant shall undertake immediate corrective action in those counties which are in non-compliance with this order and with the court's previous orders. The defendants shall consider employing state personnel who can be temporarily assigned to county departments experiencing seasonal or other difficulties in processing

applications. In addition, defendants shall consider imposing fiscal sanctions on county departments that are not in compliance with this court's orders.

[5] 11. That in view of defendants protracted non-compliance with previous court orders, but principally to insure future compliance, defendants are ordered to pay each applicant who is determined to be eligible for AFDC or Medicaid a remedial fine of fifty dollars ($50.00) for each week or fraction thereof that his or her application was delayed beyond the relevant time limit without "good cause." Defendants will be given ninty (90) days from the date of this order to bring the county departments into compliance with federal law and the terms of this order. At the end of ninety (90) days, defendants are ordered to send each applicant who is sent an initial AFDC check or favorable Medicaid notice of decision a separate check in the amount required by the terms of this paragraph. A decision by defendants that an applicant is not entitled to payment provided for by this paragraph shall be subject to the statutory appeals procedure. *See* N.C.G.S.

12. That any money paid to an applicant as a result of this order shall not be recoverable by defendants. Nor shall the money paid to a successful applicant be treated as income or reserve for the purpose of determining public assistance eligibility or benefit levels.

13. That until further order of court, plaintiffs' counsel are allowed access to the public assistance case files in all of any ten county departments of social services of their choice, to investigate the accuracy of the defendants' monthly statistical reports. Defendants are ordered to pay the plaintiffs' reasonable attorneys' fees for this investigation.

14. That defendants shall continue to comply with the earlier order of this court, as modified herein, that they

prevent county departments of social services from denying or rejecting AFDC or Medicaid applications on the basis of an applicant's delay in obtaining and submitting information needed to establish eligibility. Such delay shall include, but not be limited to, an applicant's failure to be present for a home visit, or failure to bring in medical bills necessary for "certification" or "authorization."

However, defendants are not required to hold cases open more than six (6) months from the date of application unless there is "good cause" to do so. "Good cause" for holding a case open would exist when

(a) The applicant's efforts to obtain the missing information have been fruitless and he or she has made reasonable attempts within the initial six months to obtain the information. Reasonable shall mean at least two attempts by the applicant to obtain the information following notification that he or she is responsible for providing the information.

(b) Despite reasonable efforts by the applicant during the initial six months a collateral source has failed to provide necessary information. Reasonable shall mean two attempts by the applicat to make the source provide the information.

(c) The applicant has been unable to obtain the necessary information due to lengthly illness or deteriorating mental or physical condition.

(d) Any other reason determined reasonable by the local or state hearing officer.

Where "good cause" exists, defendants shall hold the case open for an additional six (6) months. Where defendants determine that "good cause" does not exist and deny an application at the end of the first six months, the applicant shall have the right to appeal the decision pursuant to N.C.G.S. § 108A-79.

15. That the defendants shall continue to insure that all counties take all public assistance applications on the first day the person appears desiring to apply. Furthermore, defendants shall continue to insure that all persons who appear at a county department of social services desiring to apply for public assistance shall be informed in writing and verbally of their right to make application without delay. The text of the notice provided to would-be applicants shall be the same as that provided in the attachment to the August 12, 1976 order in case.

16. That defendants shall send copies of all county letters, manual changes, official bulletins and county monitoring reports pertaining to the processing of AFDC and Medicaid applications to plaintiffs' counsel.

17. That the defendants shall submit reports to the court after ninety (90) days, and agian offer one hundred and eighty (180) days, detailing what steps have been taken to comply with this order, what results have been obtained, and what problems are continuing.

CLERK'S MEMORANDUM

Enclosed is a copy of the opinion. Judgement was entered on May 5, 1983. Counsel desiring to tax costs against the unsuccessful party under Rule 39, FRAP, is requested to furnish an itemized statement from the printer showing the actual cost per page for reproducing the brief and appendix.

WILLIAM K. SLATE, II *Clerk*

RULE 39. COSTS

(a) To Whom Allowed. Except as otherwise provided by law, if an appeal is dismissed, costs shall be taxed against the appellant, unless otherwise agreed by the parties or ordered by the court; if a judgment is affirmed, costs shall be taxed against the appellant unless otherwise ordered; if a judgment is reversed, cost shall be taxed against the appellee unless otherwise ordered; if a judgment is affirmed or reversed in part, or is vacated, costs shall be allowed only as ordered by the court.

(b) Costs For and Against the United States. In cases involving the United States or an agency or officer thereof, if an award of costs against the United States is authorized by law, costs shall be awarded in accordance with the provisions of subdivision (a); otherwise, costs shall not be awarded for or against the United States.

(c). Cost of Briefs, Appendices, and Copies of Records. Unless otherwise provided by local rule, the cost of printing, or otherwise producing necessary copies of briefs, appendices, and copies of records authorized by Rule 30(f) shall be taxable in the court of appeals at rates not higher than those generally charged for such work in the area where the clerk's office is located.

(d) Bill of Costs; Objections; Costs to be Inserted in Mandate or Added Later. A party who desires such costs to be taxed shall state them in an itemized and verified bill of costs which he shall file with the clerk, with proof of service, within 14 days after the entry of judgment. Objections to the bill of costs must be filed within 10 days of service on the party against whom costs are to be taxed unless the time is extended by the court. The clerk shall prepare and certify an itemized statement of costs taxed in the court of appeals for insertion in the mandate, but the issuance of the mandate shall not be delayed for taxation of costs and if the mandate has been issued before final determination of costs, the statement, or any amendment thereof, shall be added to the mandate upon request by the clerk of the court of appeals to the clerk of the district court.

(e) Costs on Appeal Taxable in the District Courts. Costs incurred in the preparation and transmission of the record, the cost of the reporter's transcript, if necessary for the determination of the appeal, the premiums paid for cost of supersedeas bonds or other bonds to preserve rights pending appeal, and the fee for filing the notice of appeal shall be taxed in the district court as costs of the appeal in favor of the party entitled to costs under this rule.

STATE PLANS IN EFFECT JULY 25, 1962: AUTOMATIC CONFORMITY TO AMENDMENTS

Section 104(b) of Pub. L. 98-543 provided that: "Each State plan approved under title IV of the Social Security Act [this subchapter] and in effect on the date of the enactment of this Act [July 25, 1962] shall be deemed for purposes of such title [this subchapter], without the necessity of any change in such plan, to have been conformed with the amendments made by subsection (a) of this section [to sections 601-604, 606-608, 1202 and 1352 of this title]."

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 603, 609 of this title.

§602. State plans for aid and services to needy families with children

(a) Contents

A State plan for aid and services to needy families with children must (a) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them; (2) provide for financial participation by the State; (3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan; (4) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for aid to families with dependent children is denied or is not acted upon with reasonable promptness; (5) provide such methods of administration (including after January 1, 1940, methods relating to the establishment and matinenance of personnel standards on a merit basis except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

and (6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports; (7) except as may be otherwise provided in clause (8), provide that the State agency shall, in determining need, take into consideration any other income and resources of any child or relative claiming aid to families with dependent children, or of any other individual (living in the same home as such child and relative) whose needs the State determines should be considered in determining the need of the child or realtive claiming such aid, as well as any expenses reasonably attributable to the earning of any such income; (8) provide that, in making the determination under clause (7), the State agency —

(A) shall with respect to any month disregard —

(i) all of the earned income of each dependent child receiving aid to families with dependent children who is (as determined by the State in accordance with standards prescribed by the Secretary) a full-time student or part-time student who is not a full time employee attending a school, college, or university or a course of vocational or technical training designed to fit him for gainful employment, and

(ii) in the case of earned income of a dependent child not included under clause (i), a relative receiving such aid, and any other individual (living in the same home as such relative and child) whose needs are taken into account in making such determination, the first $30 of the total of such earned income for such month plus one-third of the remainder of such income for such month (except that the provisions of this clause (ii) shall not apply to earned income derived from participation on a project maintained under the programs established

by section 632(b)(2) and (3) of this title); and

(B)(i) may, subject to the limitations prescribed by the Secretary, permit all or any portion of the earned or other income to be set aside for future identifiable needs of a dependent child, and (ii) may, before disregarding the amounts referred to in subparagraph (A) and clause (i) of this subparagraph, disregard not more than $5 per month of any income;

except that, with respect to any month, the State agency shall not disregard any earned income (other than income referred to in subparagraph (B)) of —

(C) any one of the persons specified in clause (ii) of subparagraph (A) if such person—

(i) terminated his employment or reduced his earned income without good cause within such period (of not less than 30 days) preceding such month as may be prescribed by the Secretary; or

(ii) refused without good cause, within such period preceding such month as may be prescribed by the Secretary, to accept employment in which he is able to engage which is offered through the public employment offices of the State, or is otherwise offered by an employer if the offer of such employer is determined by the State of local agency administering the State plan, after notification by him, to be a bona fide offer of employment; or

(D) any of such persons specified in clause (ii) of subparagraph (A) if with respect to such month the income of the persons so specified (within the meaning of clause (7)) was in excess of their need as determined by the State agency pursuant to clause (7) (without regard to clause (8)), unless, for any one of the four months preceding such month, the needs of such persons were met by the furnishing of aid under the plan;

(9) provide safeguards which restrict the use of[1] disclosure of information concerning applicants or recipients to purposes directly connected wth (A) the administration of the plan of the State approved under this part, the plan or program of the State under part B, C, or D of this subchpater or under subchapter I, X, XIV, XVI, XIX, or XX of this chapter, or the supplemental security income program established by subchapter XVI of this chapter, (B) any investigation, prosecution, or criminal or civil proceeding, conducted in connection with the administration of any such plan or program, and (C) the administration of any other Federal or federally assisted program which provides assistance, in cash or in kind, or services, directly to individuals on the basis of need; and the safeguards so provided shall prohibit disclosure, to any committee or a legislative body, of any information which identifies by name or address any such applicant or recipient; **(10) provide, effective July 1, 1951, that all individuals wishing to make application for aid to families with dependent children shall have opportunity to do so, and that aid to families with dependent children shall, subject to paragraphs (25) and (26), be furnished with reasonable promptness to all eligible individuals;** (11) provide for prompt notice (including the transmittal of all relevant information) to the State child support collection agency (established pursuant to part D of this subchapter) of the furnishing of aid to families with dependent children with respect to a child who has been deserted or abandoned by a parent (including a child born out of wedlock without regard to whether the paternity of such child has been established); (12) provide, effective October 1, 1950, that no aid will be furnished any individual under the plan with respect to any period with respect to which he is receiving old-age

[1] So in original. Probably should read "or".

assistance under the State plan approved under section 302 of this title;

(13), (14) Repealed. Pub. L. 93-647, §3(1)(2), Jan. 4, 1975, 88 Stat. 2348.

(15) provide as part of the program of the State for the provision of services under subchapter XX of this chapter (A) for the development of a program, for each appropriate relative and dependent child receiving aid under the plan and for each appropriate individual (living in the same home as a relative and child receiving such aid) whose needs are taken into account in making the determination under clause (7), for preventing or reducing the incidence of births out of wedlock and otherwise strengthening family life, and for implementing such program by assuring that in all appropriate cases (including minors who can be considered to be sexually active) family planning services are offered to them, and are provided promptly (directly or under arrangements with others) to all individuals voluntarily requesting such services but acceptance of family planning services provided under the plan shall be voluntary on the part of such members and individuals and shall not be a prerequisite to eligibility for or the receipt of any other service under the plan; and (B) to the extent that services provided under this clause or clause (14) are furnished by the staff of the State agency or the local agency administering the State plan in each of the political subdivisions of the State, for the establishment of a single organizaitonal unit in such State or local agency, as the case may be, responsible for the furnishing of such services; (16) provide that where the State agency has reason to believe that the home in which a relative and child receiving aid resides is unsuitable for the child because of the neglect, abuse, or exploitation of such child it shall bring such condition to the attention of the

appropriate court or law enforcement agencies in the State, providing such data with respect to the situation it may have:

(17), (18) repealed. Pub. L. 93-647, § 101(c)(8), Jan. 4, 1975, 88 Stat. 2360.

(19) provide:

(A) that every individual, as a condition of eligibility for aid under this part, shall register for manpower services, training, and employment as provided by regulations of the Secretary of Labor, unless such individual is—

(i) a child who is under age 16 or attending school full time;

(ii) a person who is ill, incapacitated, or of advanced age;

(iii) a person so remote from a work incentive project that his effective participation is precluded;

(iv) a person whose presence in the home is required because of illness or incapacity of another member of the household;

(v) a mother or other relative of a child under the age of six who is caring for the child; or

(vi) the mother or other female caretaker of a child, if the father or another adult male relative is in the home and not excluded by clause (i), (ii), (iii), or (iv) of this subparagraph (unless he has failed to register as required by this subparagraph, or has been found by the Secretary of Labor under section 633(g) of this title to have refused without good cause to participate under a work incentive program or accept employment as described in subparagraph (F) of this paragraph);

and that any individual referred to in clause (v) shall be advised of her option to register, if she so desires, pursuant to this paragraph, and shall be informed of the child care services (if any) which will be available to her in the event she

should decide so to register.

(B) that aid under the plan will not be denied by reason of such registration or the individual's certification to the Secretary of Labor under subparagraph (G) of this paragraph, or by reason of an individual's participation on a project under the program established by section 632(b)(2) or (3) of this title;

(C) for arrangements to assure that there will be made a non-Federal contribution to the work incentive programs established by part C by appropriate agencies of the State or private organizations of 10 per centum of the cost of such programs, as specified in section 635(b) of this title;

(D) that (i) training incentives authorized under section 634 of this title, and income derived from a special work project under the program establihsed by section 632(b)(3) of this title shall be disregarded in determining the needs of an individual under section 602(a)(7) of this title, and (ii) in determining such individual's needs the additional expenses attributable to his participation in a program established by section 632(b)(2) or (3) of this title shall be taken into account;

(E) Repealed. Pub. L. 92-223, §3(a)(5), Dec. 28, 1971, 85 Stat. 804.

TITLE 42—THE PUBLIC HEALTH AND WELFARE

(Aug. 14, 1935, ch. 531, title XVIII, § 1880, as added Sept. 30, 1976, Pub. L. 94-437, title IV, §401(b), 90 Stat. 1408.)

REFERENCES IN TEXT

Section 403 of such Act, referred to in subsec. 9) is section 403 of the Indian health Care Improvement Act, pub. L. 94-437, which is set out as a note under section 1671 of Title 25, Indians.

MEDICARE PAYMENTS NOT CONSIDERED IN DETERMINING APPROPRIATIONS FOR INDIAN HEALTH CARE

Section 401(c) of Pub. L. 94-437 provided that: "Any payments received for services provided to beneficiaries hereunder [under this section] shall not be considered in determining appropriations for health care and services to Indians."

PREFERENCE IN SERVICES FOR INDIANS WITH MEDICARE COVERAGE NOT AUTHORIZED

Section 401(d) of Pub. L. 94-438 provided that: "Nothing herein authorizes the Secretary to privde services to an Indian beneficiary with coverage under title XVIII of the Social Security Act, as amended [this subchapter], in preference to an Indian beneficiary without such coverage."

SUBCHAPTER XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

SUBCHAPTER REFERRED TO IN OTHER SECTIONS

This subchapter is referred to in sections 247d, 254c, 254h, 294v, 300e-6, 602, 603, 713, 1301, 1306, 1308, 1309, 1315, 1316, 1318, 1319, 1320a-1, 1320a-2, 1382, 1382e, 1382g, 1383c, 1395b-1, 1395v, 1395x, 1395z, 1395cc, 1397a, 1397b, 1397c, 2689e, 3024, 3028 of this title; title 12 section 1715w; title 38 section 4108.

SUBCHAPTER REFERRED TO IN D.C. CODE

This subchapter is referred to in sections 1-266, 1-267 of the District of Columbia Code.

§1396 Appropriations

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other

services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchpater. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for medical assistance.

(Aug. 14 1935, ch. 531, title XIX, § 1901, as added July 30, 1965, Pub. L. 89-97, title I, §121(a). 79 Stat. 343, and amended Dec. 31, 1973, Pub. L. 93-233, § 13(a)(1), 87 Stat. 960.)

AMENDMENTS

1973—Pub. L. 93-233 substituted in item (1) "disabled individuals" for "permanently and totally disabled individuals".

(Aug. 14, 1935, ch. 531, title XIX, § 1901, as added July 30, 1965, Pub. L. 89-97, title I, § 121(a), 79 Stat. 343, and amended Dec. 31, 1973, Pub. L. 93-233, § 13(a)(1), 87 Stat. 960.)

AMENDMENTS

1973—Pub. L. 93-233 substituted in item (1) "disabled individuals" for "permanently and totally disabled individuals".

EFFECTIVE DATE OF 1973 AMENDMENT

Amendment by Pub. L. 93-233 effective with respect to payments under section 1396b of this title for calendar quarters commencing after Dec. 31, 1973, see section 13(d) of Pub. L. 93-233, set out as an Effective Date of 1973 Amendment note under section 1396a of this title.

§ 1396a State plans for medical assistance

(a) Contents

A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1396b of this title are authorized by this subchpater; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistnace under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, and (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and

other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency;

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the adminsitration of the plan, or proivde for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI of this chapter (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies administering the supplemental security income program established under subchapter XVI of the State plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter.

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and vertification of such reports;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and receipients to purposes directly connected with the administration of the plan;

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance

shall be furnished with reasonable promptness to all eligible individuals.

(9) provide—

(A) that the State health agency, or other appropriate State medical agency whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title), shall be responsible for establishing and maintinaing health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services, and

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relatingto health, for such institutions;

(10) provide—

(A) for making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under subchpater I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter;

(B) that the medical assistance made available to any individual described in clause (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(i) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in clause (A); and

(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchpater XVI of this chapter, as the case may be, as determined in accordance with standards prescribed by the Secretary—

(i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under

any such State plan or to have paid with respect to them supplemental security income benefits under subchapter XVI of this chapter, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and

(ii) That the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1396d(a) of this title to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of such services of the same amount, duration, and scope, to individuals of any other ages (II) the making available of supplementary medical insurance benefits under part B of subchapter XVIII of this chapter to individuals eligible therefor (either pursuant to an agreement entered into under section 1395v of this title or by reason of the payment of premiums under such subchapter by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of subchapter XVIII of this chapter for individuals eligible for benefits under such part, shall not, by reason of the paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, and (III) the making of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not,

by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope to any other individuals not described in clause (A);

(11)(A) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan, and (B) effective July 1, 1969, provide, to the extent prescribed by the Secretary, for entering into agreements, with any agency, institution, or organization receiving payments for part or all of the cost of plans or projects under subchapter V of the chapter, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such plan or project under subchapter V of this form prescribed by the agency and signed under a penalty of perjury.

§ 435.908 Assistance with application.

The agency must allow an individual or individuals of the applicant's choice to accompany, assist, and represent the applicant in the application process or a redetermination of eligibility.

§ 435.909. Automatic entitlement to Medicaid following a determination of eligibility under other programs.

The agency must not require a separate application for Medicaid from an individual, if—

(a) The individual receives AFDC; or

(b) The agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act for determining Medicaid eligibility; and—

(1) The individual receives SSI;

(2) The individual receives a mandatory State supplement under either a federally-administered or State-

administered program; or

(3) The individual receives an optional State supplement and the agency provides Medicaid to recipients of optional supplements under § 435.230.

(3) The individual receives an optional State supplement and the agency provides Medicaid to recipients of optional supplements under § 435.230.

§ 435.910 Use of social security number.

(a) The agency must request, on the application, the social security number (SSN) of each individual (including children) for whom Medicaid services are requested.

(b) The agency must advise the applicant of—

(1) Whether disclosure of the SSN is mandatory or voluntary;

(2) The statute or other authority under which the agency is requesting the applicant's SSN; and

(3) The uses the agency will make of the SSN.

(c) The agency must not make disclosure mandatory unless it had a system of records in operation before January 1, 1975, that met the following conditions:

(1) It was used in the administration of the Medicaid program; and

(2) Under statute or regulation, it required an applicant to disclose his SSN to verify his identity.

(d) If disclosure of the SSN is voluntary, the agency must not deny Medicaid to an otherwise eligible applicant for failure or refusal to disclose or apply for a SSN and must inform the applicant that he is not required to disclose or apply for a SSN.

(e) If an applicant cannot recall his SSN or has not been issued a SSN, and wishes to secure one, the agency must—

(1) Assist the applicant in completing an application for a SSN;

(2) Obtain evidence required under SSA regulations to establish the age, the citizenship or alien status, and the true

identity of the applicant; and

(3) Either sent the application to SSA or, if there is evidence that the applicant has previously been issued a SSN, request SSA to verify the number.

(f) The agency must not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's SSN by SSA.

DETERMINATION OF MEDICAID ELIGIBILITY

§ 435.911 Timely determination of eligibility.

(a) The agency must establish time standards for determining eligibility and inform the applicant of what they are. These standards may not exceed—

(1) Sixty days for applicants who apply for Medicaid on the basis of disability; and

(2) Forty-five days for all other applicants.

(b) The time standards must cover the period from the date of application to the date the agency mails notice of its decision to the applicant.

(c) The agency must determine eligibility within the standards except in unusual circumstances, for example—

(1) When the agency cannot reach a decision because the applicant or an examining physician delays of fails to take a required action, or

(2) When there is an administrative or other emergency beyond the agency's control.

(d) The agency must document the reasons for delay in the applicant's case record.

(e) The agency must not use the time standards—

(1) As a waiting period before determining eligibility; or

(2) As a reason for denying eligibility (because it has not determined eligibility within the time standards).

[44 FR 17937, Mar. 23, 1979, as amended at 45 FR 24887, Apr. 11, 1980]

§ 435.912 Adequate notice.

The agency must send each applicant a written notice of the agency's decision on his application, and, if eligibility is denied, the reasons for the action, the specific regulation supporting the action, and an explanation of his right to request a hearing. (See Subpart E of Part 431 of this subchapter for rules on hearings.)

§ 435.913 Case documentation.

(a) The agency must include in each applicant's case record facts to support the agency's decision on his application.

(b) The agency must dispose of each application by a finding of eligibility or ineligibility, unless—

(1) There is an entry in the case record that the applicant voluntarily withdrew the application, and that the agency sent a notice confirming his decision;

(2) There is a supporting entry in the case record that the applicant has died; or

(3) There is a supporting entry in the case record that the applicant cannot be located.

§ 435.914. Effective date.

(a) The agency must make eligibility for Medicaid effective no later than the third month before the month of application if the individual—

(1) Received Medicaid services, at any time during that period, of a type covered under the plan; and

(2) Would have been eligible for Medicaid at the time he received the services if he had applied (or someone had applied for him), regardless of whether the individual is alive when application for Medicaid is made.

(b) The agency may make eligibility for Medicaid effective on the first day of a month if an individual was eligible at any time during that month.

(c) The State plan must specify the date on which eligibility will be made effective.

REDETERMINATIONS OF MEDICAID ELIGIBILITY

§ 435.916 Periodic redeterminations of Medicaid eligibility.

(a) The agency must redetermine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least, every 12 months, however—

(1) The agency may consider blindness as continuing until the review physician under § 435.531 determines that a recipient's vision has improved beyond the definition of blindness contained in the plan; and

(2) The agency may consider disability as continuing until the review team under § 435.541 determines that a recipient's disability no longer meets the definition of disability contained in the plan.

(b) *Procedures for reporting changes.* The agency must have procedures designed to ensure that recipients make timely and accurate reports of any change in circumstances that may affect their eligibility.

(c) *Agency action on information about changes.* (1) The agency must promptly redetermine eligibility when it receives information about changes in a recipient's circumstances that may affect his eligibility.

(2) If the agency has information about anticipated changes in a recipient's circumstances, it must redetermine eligibility at the appropriate time based on those changes.

§ 435.919 Timely and adequate notice.

(a) The agency must give recipients timely and adequate notice of proposed action to terminate, discontinue, or suspend their eligibility or to reduce or discontinue services they may receive under Medicaid.

(b) The notice must meet the requirements of Subpart E of Part 431 of this subchapter.

[44 FR 17937, Mar. 23, 1979, as amended at 45 FR 24887, Apr. 11, 1980]

PART 206—APPLICATION, DETERMINATION OF ELIGIBILITY AND FURNISHING ASSISTANCE—PUBLIC ASSISTANCE PROGRAMS

§ 206.10 Application, determination of eligibility and furnishing of assistance.

(a) *State plan requirements.* A State plan under title I, IV—A, X, XIV, or XCI(AABD), of the Social Security Act shall provide that:

(1) Each individual wishing to do so shall have the opportunity to apply for assistance under the plan without delay. Under this requirement:

(i) Each individual may apply under whichever of the State plan plans he chooses;

(ii) The agency shall require a written application, signed under a penalty of perjury, on a form prescribed by the State agency, from the applicant himself, or his authorized representative, or, where the applicant is incompetent or incapacitated, someone acting responsibily for him;

(iii) An applicant may be assisted, if he so desires, by an individual(s) of his choice (who need not be a lawyer) in the various aspects of the application process and the redetermination of eligibility and may be accompanied by such individual(s) in contacts with the agency and when so accompanied may also be represented by them.

(iv)—(v) [Reserved]

(vi) Every recipient in a State which provides a supplemental payment under § 233.27 of this chapter shall have an opportunity to request that payment without delay.

(b) For assistance under title IV—A prior to July 1, 1975, the agency shall request on the application the social security number (SSN) of each individual (including children) for whom assistance is requested. Under this requirement, the agency shall advise the applicant whether disclosure of such number is requested, and what uses will be made of it. Disclosure of the SSN may be made

mandatory only if the State had in existence and operating prior to January 1, 1975, a system of welfare or Medicaid records for which disclosure of the SSN was required, by statute or regulation, in order to verify the identity of the individual. If any individual cannot provide a SSN either because he has not been issued one or he does not know his SSN, and wishes to secure one, the agency shall assist him in filling out an application for such number on such forms and under such procedures as may be required by the Social Security Administration (SSA) and shall transmit it to the SSA. Under this requirement, the agency shall also obtain such evidence as may be required under SSA regulations to establish the age, citizenship or alien status, and true identity of such applicant, and, where the case record attests that a previous social security number has been issued, request verification of the number by SSA. Where disclosure of the SSN is voluntary, no individual who is otherwise eligible shall be denied assistance because of failure or refusal to disclosure or apply for a SSN, and the indivudual shall be so informed. *

(c) The agency shall not deny or delay assistance to an eligible indivudual pending issuance by SSA or verification by the agency of his SSN.

(2)(i) Applicants shall be informed about the elegibility requirements and their rights and obligations under the program. Under this requirement individuals are given information in written form, and orally as appropriate, about coverage, conditions of eligibility, scope of the program, and related services available, and the rights and responsibilities of applicants for and recipients of assistance. Specifically developed bulletins or pamphlets explaining the rules regarding eligibility and appeals in simple, understandable terms are publicized and available in quantity.

(ii) Procudures shall be adopted which are designed to assure that recipients make timely and accurate reports of

any change in circumstances which may affect their eligibility or the amount of assistance.

(3) A decision shall be made promptly on applications, pursuant to reasonable State-established time standards not in excess of:

(i) 45 days for OAA, AFDC, AB, AABD (for aged and blind); and

(ii) 60 days for APTD, AABD (for disabled). Under this requirement, the applicant is informed of the agency's time standard in acting on applications, which covers the time from date of application under the State plan to the date that the assistance check, or notification of denial of assistance or change of award is mailed to the applicant or recipient. The State's time standards apply except in unusual circumstances (e.g., where the agency cannot reach a decision because of failure or delay on the part of the applicant or an examining physician, or because of some administrative or other emergency that could not be controlled by the agency), in which instances the case record shows the cause for the delay. The agency's standards of promptness for acting on applications or redetermining eligibility shall not be used as a waiting period before granting aid, or as a basis for denial of an application or for terminating assistance.

(4) Adequate notice shall be sent to applicants and recipients to indicate that assistance has been authorized (including the amount of financial assistance) or that it has been denied or terminated. Under this requirement, adequate notice means a written notice that contains a statement of the action taken, and the reasons for and specific regulations supporting such action, and an explanation of the indivudual's right to request a hearing.

(5)(i) Financial assistance and medical care and services incuded in the plan shall be furnished promptly to eligible indivuduals without any delay attributable to the agency's administrative process, and shall be continued regularly to

all eligible individuals until they are found to be ineligible. Under this requirement there must be arrangements to assist applicants and recipients in obtaining medical care and services in emergency situations on a 24-hour basis, 7 days a week.

(ii) Under title IV—A, assistance will be denied, delayed or discontinued pending receipt of wage information requested under § 205.56, if other evidence establishes the individual's eligibility for assistance. (6) Assistance shall begin as specified in the State plan, which:

(i) For financial assistance.

(A) Must be no later than:

(1) The date of authorization of payment, or

(2) Thirty days in OAA, AFDC, AB and AABD (as to the aged and blind), and 60 days in APTD and AABD (as to the disabled), from the date of receipt of a signed and completed application form, whichever is earlier: *Provided,* That the individuals then met all the eligibility conditions, and

(B) For purposes of Federal financial participation in OAA, AB, APTD, and AABD, may be as early as the first of the month in which an application has been received and the individual meets all the eligibility conditions; and

(C) In AFDC, for purposes of Federal financial participation, may be as early as the date of application provided that the assistance unit meets all the eligibility conditions; and

(D) In AFDC, State that pay for the month of application must prorate the payment for that month by multiplying the amount payable if payment were made for the entire month including special needs in accordance with § 233.34 by the ratio of the days in the month including and following the date of application (or, at State option, the date of authorization of payment) to the total number of days in such month. The State plan may provide for using a standard 30-day month to determine the prorated amount.

(7) In cases of proposed action to terminate, discontinue, suspend or reduce assistance, the agency shall give timely and adequate notice. Such notice shall comply with the provisions of § 205.10 of this chapter.

(8) Each decision regarding eligibility or ineligibility will be supported by facts in the applicant's or recipient's case record. Under this requirement each application is disposed of by a finding of eligibility or ineligibility unless:

(i) The applicant voluntarily withdraws his application, and there is an entry in the case record that a notice has been sent to confirm the applicant's notification to the agency that he does not desire to pursue his application; or

(ii) There is an entry in the case record that the application has been disposed of because the applicant died or could not be located.

(9) Where an individual has been determined to be eligible, eligibility will be reconsidered or redetermined:

(i) When required on the basis of information the agency has obtained previously about anticipated changes in the individual's circumstances that may affect the amount of assistance to which he is entitled or may make him ineligible; and

(iii) Periodically, within agency-established time standards, but not less frequently than every 6 months in AFDC, and every 12 months in OAA, AB, APTD, and AABD, on eligibility factors subject to change.

(A) For recipients of assistance under title IV—A, the agency shall verify that the case record contains a social security number (SSN) for each recipient, including children; if the case record does not contain a SSN, the agency shall follow the procedures set forth in paragraph (a)(1)(v) of this section for the purpose of obtaining a SSN; and

(B) For any recipient whose social security number was established as part of the case record without corroborative evidence of age, citizenship or alien status, and true identity,

the agency shall obtain verification thereof under the procedures set forth in paragraph (a)(1)(v) of this section.

(10) Standards and methods for determination of eligibility shall be consistent with the objectives of the programs, and will respect the rights of individuals under the United States Constitution, the Social Security Act, title VI of the Civil Rights Act of 1964, and all other relevant provisions of Federal and State laws.

(11) [Reserved]

(12) The State agency shall establish and maintain methods by which it shall be kept currently informed about local agencies' adherence to the State plan provisions and ot the State plan provisions and to the State agency's procedural requirements for determining eligibility, and it shall take corrective action when necessary.

(d) *Definitions.* For purposes of this section:

(1) "Applicant" is a person who has, directly, or through his authorized representative, or where incompetent or incapacitated, through someone acting responsibly for him, made application for public assistance from the agency administering the program, and whose application has not been terminated.

(2) "Application" is the action by which an individual indicates in writing to the agency administering public assistance his desire to receive assistance. The relative with whom a child is living or will live ordinarily makes application for the child for AFDC. An application is distinguished from an inquiry, which is simply a request for information about eligibility requirements for public assistance. Such inquiry may be followed by an application.

(3) "Date of Application" is the date on which the action described in (d)(2) occurs.

(Sec. 402, 411, 1102, 1106(a), Social Security Act, as amended; 49 Stat. 647, as amended; 91 Stat. 1561, 53 Stat. 1398, as ammended (42 U.S.C. 602, 611, 1302, 1306(a); and sec. 403 of Pub. L. 95-216, 91 Stat. 1561, sec 1102 of the

Social Security Act, as amended, 42 U.S.C. 1302, and Part XXIII of Pub. L. 97-35, Pub. L. 97-248, 95 Stat. 324)

38 FR 22009, Aug. 15, 1973, as amended at 44 FR 17943, Mar. 23 1979; 44 FR 26082, May 4, 1979; 44 FR 75147, Dec. 19, 1979; 47 FR 5674, Feb. 5, 1982; 47 FR 41112, Sept. 17, 1982

* * *

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subsec. (g) of this section, see section 201(12) of Pub. L. 94-274, title II, Apr. 21, 1976, 90 Stat. 390 set out as a note under section 343 of Title 7, Agriculture.

FISCAL YEAR TRANSITION PERIOD OF JULY 1, 1976, THROUGH SEPTEMBER 30, 1976, DEEMED PART OF FISCAL YEAR BEGINNING JULY 1, 1975

Fiscal year transition period of July 1, 1976, through Sept. 30, 1976 deemed part of fiscal year beginning July 1, 1975, for purposes of subsecs. (c) and (f) of this section, see section 204(7) of Pub. L. 94-274, title II, Apr. 21, 1976, 90 Stat. 392, set out as a note under section 390e of Title 7, Agriculture.

NONDUPLICATION OF PAYMENTS TO STATES: PROHIBITION OF PAYMENTS AFTER DECEMBER 31, 1969

Prohibition of payments under this subchapter to States with respect to aid or assistance in form of medical or other type of remedial care for any period for which States received payments under subchapter XIX of this chapter or for any period after Dec. 31, 1969, see section 1396b of this title.

FEDERAL PERCENTAGE OF STATE EXPENDITURES FOR SECTION 602(a)(14), (15) SERVICES FROM JAN. 2, 1968, AND BEFORE JULY 1, 1969

Section 201(h) of Pub. L. 90-248 provided that

notwithstanding subsec. (a)(3)(A) of this section, as amended by section 201(c) of Pub. L. 90-248, the rate specified un subsec. (a)(3)(A) of this section was to be 85 per centum, rather than 75 per centum, with respect to expenditures for services furnished pursuant to section 602(a)(14) and (15) of this title, made on or after Jan. 2, 1968, and prior to July 1, 1969.

RATE OF PAYMENTS FOR PUERTO RICO, THE VIRGIN ISLANDS, AND GUAM

Section 248(b) of Pub. L. 90-248 provided that: "Notwithstanding subparagraphs (A) and (B) of section 403(a)(3) of such Act (as amended by this Act) [subsec. (a)(3) of this section], the rate specified in such subparagraphs in the case of Puerto Rico, the Virgin Islands and Guam shall be 60 per centum (rather than 75 or 85 per centum)."

REPORT TO PRESIDENT AND CONGRESS: RECOMMENDATIONS AS TO CONTINUATION AND MODIFICATION OF AMENDMENT

Section 108(d) of Pub. L. 87-543 provided that the Secretary submit to the President, for transmission to Congress prior to Jan. 1, 1967, a full report of the administration of the provisions of the amendments made by section 108 of Pub. L. 87-543 to this section and section 606 of this title, including the experiences of each of the States in making protective payments under the provisions of their respective State plans which are in accord with amendments to this section and section 606 of this title by section 108 of Pub. L. 87-543, together with his recommendations as to continuation and modification in these amendments.

Provisions applicable in the case of expenditures under a State plan approved under this subchapter, made during the period beginning Oct. 1, 1962, and ending with the close of June 30, 1967, see section 202(e) of Pub. L. 87-543, set out as an Effective Date of 1962 Amendment note above.

STATE PLANS IN EFFECT JULY 25, 1962: AUTOMATIC CONFORMITY TO AMENDMENTS

State plans in effect July 25, 1962, deemed to have been conformed to amendment of subsec. (b)(2)(B) of this section by section 104(b) of Publ. L. 87-543, set out as a note under section 601 of this title.

CROSS REFERENCES

Navajo and Hopi Indians, additional Federal contributions in connection with rehabilitation programs, see section 639 of Title 25, Indians.

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 603a, 604, 608, 609, 643, 652, 1315, 1318, 1319, 1397a of this title; title 25 section 639.

SECTION REFERRED TO IN D.C. CODE

This section is referred to in section 3-217 of the District of Columbia Code.

§ 603a. Reimbursement of expenses

For purposes of section 603 of this title, expenses incurred to reimburse State employment offices for furnishing information requested of such offices prusuant to the third sentence of section 49b(a) of title 29, by a State or local agency administering a State plan approved under part A of subchapter IV of this chapter shall be considered to constitute expenses incurred in the administration of such State plan; and for proposes to reimburse State employment offices for furnishing information so requested by a State or local agency charged with the duty of carrying out a State plan for child support approved under part D of subchapter IV of this chapter shall be considered to constitute expenses incurred in the administration of such State plan.

(Pub. L. 94-566, title V, § 508(b), Oct. 20, 1976, 90 Stat. 2689.)

REFERENCES IN TEXT

Parts A and D of subchapter IV of this chapter, referred to in text, are classified to sections 601 et seq. and 651 et seq. of this title.

CODIFICATION

Section was not enacted as part of the Social Security Act which comprises this chapter.

§ 604. Deviation from plan

(a) Stoppage of payments

In the case of any State plan for aid and services to needy families with children which has been approved by the Secretary, if the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plan, finds—

(1) that the plan has been so changed as to impose any residence requirement prohibited by section 602(b) of this title, or that in the administration of the plan any such prohibited requirement is imposed, with the knowledge of such State agency, in a substantial number of cases; or

(2) that in the administration of the plan there is a failure to comply substantially with any provisions required by section 602(a) of this title to be included in the plan;

the Secretary shall notify such State agency that further payments will not be made to the State (or in his discretion, that payment will be limited to categories under or parts of the State plan not affected by such failure) until the Secretary is satisfied that such prohibited requirement is no longer so imposed, and that there is no longer any such failure to comply. Until he is so satisified that such prohibited requirement is no longer so imposed, and that there is no longer any such failure to comply. Until he is so satisified he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

institution certified under such title XIX [this subchapter]."

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in sections 643, 1315, 1396a of this title.

§ 1396c. Operations of state plans

If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds—

(1) that the paln had been so changed that it not longer complies with the provisions of section 1396a of this title; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will nto be made to the State (or, in his descretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

(Aug. 14, 1935, ch. 531, title XIX, § 1904, as added July 30, 1965, Pub. L. 89-97, title I, §121(a), 79 Stat. 351.)

SECTION REFERRED TO IN OTHER SECTIONS

This section is referred to in section 1316 of this title.

§ 1396d. Definitions

For purposes of this subchapter—

(a) Medical assistance

The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the

recipient makes application for assistance) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to indivuduals described in section 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter IX, XIV, or XVI, or part A of subchapter IV, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, who are—

(i) under the age of 21,

(ii) relatives specified in section 606(b)(1) of this title with whom a child is living if such child, except for section 606(a)(2) of this title, is (or would, if needy, be) a dependent child under part A of subchapter IV of this chapter,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under subchapter XVI of this chapter,

(vi) persons essential (as described in the second sentence of this subsection) to indivuduals receiving aid or assistance under State plans approved under subchapter, I, X, XIV, or XCI of this chapter, or

(vii) blind or desabled as defined in section 1382c of this title, with respect to States not eligible to participate in the State plan program established under subchapter XVI or this chapter.

but whose income and resources are insufficient to meet all of such costs—

(1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);

(2) outpatients hospital services;

(3) other laboratory and X-ray services;

(4)(A) skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older (B) effective July 1, 1969, such early and periodic screening and diagnosis of indivuduals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary; and (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;

(5) physicians' services furnished by a physician (as defined in section 1395x(r)(1) of this title), whether furnished in the office, tha patient's home, a hospital, or a skilled nursing facility, or elsewhere;

(6) medical care, or any other type of remedial care recognizes under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services;

(10) dental services;

(11) physical therapy and related services;

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in disease of the eye or by an optometrist, whichever the indivudual may

select;

(13) other diagnostic, screening, preventive, and rehabilitative services;

(14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for indivuduals 65 years of age or over in an institution for tuberculosis or mental diseases;

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traction of the State plan) as are attributable to the performance of medical and utilization review by a Professional Standards Review Organization under a contract entered into under section 1396a(d) of this title; plus

(4) Omitted

see main edition for text of (5)

(6) subject to subsection (b)(3) of this section, an amount equal to—

(A) 90 per centum of the sums expended during such a quarter within the twelve-quarter period in which a payment is made to the State pursuant to this paragraph, and

(B) 75 per centum of the sums expended during each succeeding calendar quarter.

with respect to costs incurred during such quarter (as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided dunder the State plan) which are attributable to the establishment and operation of (including the training of personal employed by) a State medicaid fraud control unit (described in subsection (q) of this section); plus

(7) an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found

necessary by the Secretary for the proper and efficient administration of the State plan.

(b) Quarterly expenditures begining after December 31, 1969

See main edition for text of (1) and (2)

(3) The amount of funds which the Secretary is otherwise obligated to pay a State, and local governments during the previous quarter in carrying out the State's plan under this subchapter.

See main edition for text of (c)

(5) In any case in which the Secretary estimates that there has been an overpayment under this section to a State on the basis of claim by such State that has been disallowed by the Secretary under section 1316(d) of this title, and such State disputes such disallowance, the amount of the Federal payment in controversy shall, at the option of the State, be retained by such State or recovered by the Secretary pending a final determination with respect to such payment amount. If such final determination is to the effect that any amount was properly disallowed, and the State chose to retain payment of the amount in controversy, the Secretary shall offset, from any subsequent payments made to such State under this subchapter, an amount equal to the proper amount of the disallowance plus interest on such amount disallowed for the period beginning on the date such amount was disallowed and ending on the date of such final determination at a rate (determined by teh Secretary) based on the average of the bond equivalent of the weekly 90-day treasury bill auction rates during such period.

(e) Transition costs of closure or conversions permitted

A state plan approved under this subchapter may include, as a cost with respect to hospital services under the plan under this subchapter, periodic expenditures made to reflect transitional allowances established with respect to a hospital closure or conversion under section 1395uu of this title.

See main edition for text of (f)

(g) Decrease in Federal medical assistance percentage of amounts paid for services furnished under State plan after June 30, 1973

(1) Subject to paragraph (3), with respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1395mm of this title),the Federal medical assistance percentage shall be decreased as follows: After an individual has received care as an inpatient in a hospital (including an institution for tuberculosis), skilled nursing facility or intermediate care facility on 60 days, or in a hospital for mental desease on 90 days (whether or not such days are consecutive), during any fiscal year, which for purposes of this section means the four calendar quarters ending with June 30, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such indivudual in the same fiscal year shall be decreased by a per centum thereof (determining under paragraph (5)) unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services (including tuberculosis hospitals), skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), there is in operation in the State an effective program of control over utilization of such services; such a showing must include evidence that—

(A) in each case for which payment is made under the State plan, a physician certified at the time of admission, or, if later, the time the indivudual applies for medical assistance under the State plan (and the physician, or a

physician assistant or nurse practitioner under the supervision of a physician, recertifies, where such services are furnished over a period of time, in such cases, at least every 60 days (or, in the case of services that are intermediate care facility services described in section 1396d(d) of this title, every year), and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services; and

See main edition for text of (B) to (D)

In determining the number of days on which an indidivual has received services described in this subsection, there shall not be counted any days with respect to which such indivudual is entitled to have payments made (in whole or in part) on his behalf under section 1395d of this title.

(2) The Secretary shall, as part of his validation procedures under the subsection, conduct timely sample onsite surveys of private and public insititutions in which recipients of medical assistance may receive care and services under a State plan approved under this subchapter, and his findings with respect to such surveys (as well as the showings of the State agency required under this subsection) shall be made available for public inspection.

(3)(A) No reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under this subsection shall take effect—

(i) if such reduction is due to the State's unsatisfactory or invalid showing made with respect to a calendar quarter beginning before January 1, 1977;

(ii) before January 1, 1978;

(iii) unless a notice of such reduction has been provided to the State at least 30 days before the date such reduction takes effect; or

(iv) due to the State's unsatisfactory or invalid

showing made with respect to a calendar quarter beginning after September 30, 1977, unless notice of such reduction has been provided to the State no later than the first day of the fourth calendar quarter following the calendar quarter with respect to which such showing was made.

(B) The Secretary shall waive application of any reduction in the Federal medical assistance percentage of a State otherwise required to be imposed under paragraph (1) because a showing by the State, made under such paragraph with respect to a calendar quarter ending after January 1, 1977, and before January 1, 1978, is determined to be either unsatisfactory under such paragraph or invalid under paragraph (2), if the Secretary determines that the State's showing made under paragraph (1) with respect to any calendar quarter ending on or before December 31, 1978, is satisfactory under such paragraph and is valid under paragraph (2).

(4)(A) The Secretary may not find the showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory if the showing is submitted to the Secretary later than the 30th day after the last day of the calendar quarter, unless the State demonstrates to the satisfaction of the Secretary good cause for not meeting such deadlines.

(B) The Secretary shall find a showing of a State, with respect to a calendar quarter under paragraph (1), to be satisfactory under such paragraph with respect to the requirement that the State conduct annual onsite inspections in mental hospitals, skilled nursing facilities and immediate care facilities under paragraph (26) and (31) of section 1396a(a) of this title, if the showing demonstrates that the State has conducted such an onsite inspection during the 12-month period ending on the last date of the calendar quarter—

(i) in each of not less than 98 per centum of the number of such inspection, and

(ii) in every such hospital or facility which has 200 or more beds,

and that, with respect to such hospitals and facilities not inspected within such period, the State has exercised good faith and due diligence in attempting to conduct such inspection, or if the State demonstrates to the satisfaction of the Secretary that it would have made such a showing but for failing of a technical nature only.

(5) In the case of a State's unsatisfactory of invalid showing made with respect to a type of facility or institional services in a calendar quarter, the per centum amount of the reduction of the State's Federal medical assistance percentage for that type of services under paragraph (1) is equal to 33 1/3 per centum mulitplied by a fraction, the denominator of which is equal to the total number of patients receiving that type of services in that quarter under the State plan in facilities or institutions for which a showing was required to be made under this subsection, and the numerator of which is equal to the number of such patients receiving such type of services in that quarter in those facilities or institutions for which a satisfactory and valid showing was not made for that calendar quarter.

(6) The Secretary shall submit to Congress, not later than sixty days after the end of such calendar quarter, a report on—

(A) his determination as to whether or not each showing, made under paragraph (1) by a State with respect to the calendar quarter, has been found to be satisfactory under such paragraph;

(B) his review (through onsite surveys and otherwise) under paragraph (2) of the validity of showings previously submitted by a State; and

(C) any reduction in the Federal medical assistance percentage he has imposed on a State because of its sumbittal under paragraph (1) of an unsatisfactory or invalid showing.

§ 108A-25. Creation of programs.

(a) The following programs of public assistance are hereby established, and shall be administered by the county department of social services or the Department of Human Resources under federal regulations or under rules and regulations adopted by the Social Services Commission and under the supervision of the Department of Human resources:

(1) Aid to families with dependent children;
(2) State-county special assistance for adults;
(3) Food stamp program;
(4) Foster care and adoption assistance payments;
(5) Low income energy assistance program.

(b) The program of medical assistance is hereby established as a program of public assistance and shall be administered by the county departments of social services under rules and regulations adopted by the Department of Human Resources.

(c) The Department of Human Resources is hereby authorized to accepted all grants-in-aid for programs of public assistance which may be available to the State by the federal government. The provisions of this Article shall be liberally construed in order that the State and its citizens may benefit fully from such grants-in-aid. (1937, c. 235, s. 1; c. 288, ss. 3, 31; 1949, c. 1038, s. 2; 1955, c. 1044, s. 1; 1957, c. 100, s. 1; 1965, c. 1173, s. 1; 1969, c. 546, s. 1; 1973, c. 476, s. 138; 1975, c. 92, s. 4; 1977, 2nd Sess., c. 1219, s. 9; 1979, c. 702, s. 1; 1981, c. 275, s. 1)

§ 108A-26. Certain financial assistance and in-kind goods not considered in determining assistance paid under Chapters 108A and 111.

Financial assistance and in-kind goods or services received from a governmental agency, or from a civic or charitable organization, shall not be considered in determining the amount of assistance to be paid any person under Chapter 108A and 111 of the General Statutes provided that such financial assistance and in-kind goods and services are incorporated in the rehabilitation plan of such person being assisted by the Division of Vocational Rehabilitation Services or the Divison of Services for the Blind of the the Department of Human resources, except where such goods and services are required to be considered by federal law or regulations. (1973, c. 716; 1981, c. 275, s. 1.)

Part 2. Aid to Families with Dependent Children.

§ 108A-27. Authorization of Aid to Families with Dependent Children Program.

The Department is authorized to establish and supervise an Aid to Families with Dependent Children Program. This program is to be administered by county departments of social services under federal regulations and rules and regulations of the Social Services Commission. (1981, c. 275, s. 1.)

§ 108A-28. Eligibility requirements; certain contributions to be disregarded.

(a) Assistance shall be granted to any dependent child, as defined in G.S. 108A-24(3), who:

(1) Is a resident of the State or whose mother was a resident when the child was born;

(2) Has been deprived of parental support or care by reason of a parant's death, physical or mental incapacity, or continued absence from the home;

(3) Has no adequate means of support.

(b) Assistance shall be granted to a parent or relative, as specified in G.S. 108A-24(3), with whom a dependent child lives who:

(1) Is assuming responsibility for the child's ongoing care;

(2) Is a resident of the State;

(3) Has no adequate means of support. (1937, c. 288, s. 35; 1939, c. 395, s. 1; 1941, c. 232; 1945, c. 615, s. 1; 1961, c. 533; 1965, c. 939, s. 1; 1967, c. 660; 1969, c. 546, s.c 1; 1973, c 714, ss. 1-3; c. 826; 1979, c. 162, s. 1; 1981, c. 275, s. 1.)

CERTIFICATE OF SERVICE

I hereby certify that I have served a copy of the foregoing Petition for Certiorari upon the Defendants by depositing same in the United States mail, first class postage, addressed to the counsel of record as follows:

Mr. Theodore O. Fillette, III
Legal Services of Southern Piedmont, Inc.
951 S. Independence Boulevard, Suite 600
Charlotte, North Carolina 28202

This the 1st day of August, 1983

William Woodward Webb